DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/11/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		157659	B. WING _			2/07/2013	
NAME OF PROVIDER OR SUPPLIER WOODVIEW HOME CARE LLC			STREET ADDRESS, CITY, STATE, ZIP C 3417 E STATE BLVD FORT WAYNE, IN 46805	ODE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES FY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
G 000	INITIAL COMMENTS	3	G 0	00			
		ome Health federal Medicaid This was a partial extended					
	Survey Dates: Febru Partial Extended Date	uary 6 and 7, 2013. e: February 7, 2013.					
	Facility Number: IN0	12370					
	Surveyor: Miriam Be	ennett, RN, BSN, PHNS					
	Quality Review: Joyc February 8,	e Elder, MSN, BSN, RN					
G 121	484.12(c) COMPLIAI PROFESSIONAL ST	NCE W/ ACCEPTED	G 1	21		2/13/13	
	professional standard	f must comply with accepted ds and principles that apply shing services in an HHA.					
	Based on home visit policy review, the ago clean equipment beto of 4 home visit obser	not met as evidenced by: t observation, interview, and ency failed to ensure staff ween each patient use for 4 vations with the potential to s patients. (# 1, 2, 3, 4)					
	Findings include:						
	10:55 AM, employee pressure check using Employee B failed to	observation #1 on 2/6/13 at B performed a manual blood g cuff and stethoscope. clean the blood pressure before and after patient					
ABODATODY		CLIDDLIED DEDDESENTATIVE'S SIGNATUD		TITLE		(VE) DATE	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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COMPLETED
02/07/2013
DDE
CORRECTION (X5) ON SHOULD BE COMPLETION HE APPROPRIATE DATE Y)
([]

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	P) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		157659	B. WING _			02/	07/2013
	STREET ADDRESS, CITY, STATE, ZIP CODE 3417 E STATE BLVD FORT WAYNE, IN 46805						
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G 121	the policy speaks only used by the patient at pressure cuff or steth pressure cuff cannot employee C indicated pressure cuff box and manufacturer recommanufacturer recommanufacturer is nothing indicated cleaning instructions. 7. The article titled "C Patient Care Equipmed Setting" states "One confections to home care."	40 PM, employee C indicated by to equipment in the home and does not include a blood oscope and that a blood be cleaned. At 1:00 PM, at they looked on the blood at stethoscope box for mendations of cleaning and atting these items have Cleaning and Disinfection of the items for transmitting re and hospice patients is	G.	121			
	medical equipment. those that come in comucous membranes. items may include a blacement of the computer keyboard, staken into the home, Disinfection of Patien patient care equipme hospice staff as well a in the home would be is called non-critical acausing an infection in patient care equipme cuffs, stethoscopes) of with infectious agents contribute to the trans. Therefore, non-critical surfaces should be dieparted to the trans. Therefore, non-critical surfaces should be dieparted to the trans.	smission of infections. Il medical equipment sinfected with an					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		157659	B. WING			02/07/2013	
	NAME OF PROVIDER OR SUPPLIER WOODVIEW HOME CARE LLC STREET ADDRESS, CITY, STATE, ZIP CODE 3417 E STATE BLVD FORT WAYNE, IN 46805						
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G 121	vital sign equipment a disinfected in the hor placing the equipmer use on another patier disinfection most compiece of equipment or disposable cloth or prodisinfectant Bringi devices into the home cleaned and disinfect reservoir for transmississississississississississississis	ation. It is suggested that and supplies be cleaned and the after use and prior to to the back in the nursing bag for the sum of the setting, and the sum of the setting, and the sum of the setting and the sum of the sum	G 12	21			